

#### § 409.34

skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in §409.32(b). Personal care services include, but are not limited to, the following:

- (1) Administration of routine oral medications, eye drops, and ointments;
- (2) General maintenance care of colostomy and ileostomy;
- (3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;
- (4) Changes of dressings for non-infected postoperative or chronic conditions;
- (5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
- (6) Routine care of the incontinent patient, including use of diapers and protective sheets;
- (7) General maintenance care in connection with a plaster cast;
- (8) Routine care in connection with braces and similar devices;
- (9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;
- (10) Routine administration of medical gases after a regimen of therapy has been established;
- (11) Assistance in dressing, eating, and going to the toilet;
- (12) Periodic turning and positioning in bed; and
- (13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

[48 FR 12541, Mar. 25, 1983, as amended at 63 FR 26307, May 12, 1998; 64 FR 41681, July 30, 1999]

#### 42 CFR Ch. IV (10–1–03 Edition)

#### § 409.34 Criteria for “daily basis”.

(a) To meet the daily basis requirement specified in §409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

#### § 409.35 Criteria for “practical matter”.

(a) *General considerations.* In making a “practical matter” determination, as required by §409.31(b)(3), consideration must be given to the patient’s condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first \$500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

(b) *Examples of circumstances that meet practical matter criteria.* (1) *Beneficiary’s condition.* Inpatient care would be required “as a practical matter” if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

(2) *Economy and efficiency.* Even if the beneficiary’s condition does not preclude transportation, inpatient care might be more efficient and less costly

if, for instance, the only alternative is daily transportation by ambulance.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

#### **§ 409.36 Effect of discharge from posthospital SNF care.**

If a beneficiary is discharged from a facility after receiving posthospital SNF care, he or she is not entitled to additional services of this kind in the same benefit period unless—

(a) He or she is readmitted to the same or another facility within 30 calendar days following the day of discharge (or, before December 5, 1980, within 14 calendar days after discharge); or

(b) He or she is again hospitalized for at least 3 consecutive calendar days.

### **Subpart E—Home Health Services Under Hospital Insurance**

#### **§ 409.40 Basis, purpose, and scope.**

This subpart implements sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

[59 FR 65493, Dec. 20, 1994]

#### **§ 409.41 Requirement for payment.**

In order for home health services to qualify for payment under the Medicare program the following requirements must be met:

(a) The services must be furnished to an eligible beneficiary by, or under arrangements with, an HHA that—

(1) Meets the conditions of participation for HHAs at part 484 of this chapter; and

(2) Has in effect a Medicare provider agreement as described in part 489, subparts A, B, C, D, and E of this chapter.

(b) The physician certification and recertification requirements for home health services described in § 424.22.

(c) All requirements contained in §§ 409.42 through 409.47.

[59 FR 65494, Dec. 20, 1994]

#### **§ 409.42 Beneficiary qualifications for coverage of services.**

To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) *Confined to the home.* The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in section 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act, respectively.

(b) *Under the care of a physician.* The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of podiatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under State law.

(c) *In need of skilled services.* The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under § 424.22 of this chapter.

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.)

(2) Physical therapy services that meet the requirements of § 409.44(c).

(3) Speech-language pathology services that meet the requirements of § 409.44(c).

(4) Continuing occupational therapy services that meet the requirements of § 409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.

(d) *Under a plan of care.* The beneficiary must be under a plan of care that meets the requirements for plans of care specified in § 409.43.

(e) *By whom the services must be furnished.* The home health services must be furnished by, or under arrangements made by, a participating HHA.

[59 FR 65494, Dec. 20, 1994; 60 FR 39122, Aug. 1, 1995]